

Noel R. Williams, M.D.
Patient Information Sheet

NAME: _____
(FIRST) (MIDDLE) (LAST)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____/C ell _____

Employer: _____ Are you a student? Y/N

Primary Care Physician: _____ PCP Number: _____

How did you hear about our practice? _____

Primary Insurance <i>(Please complete all fields or your claim cannot be filed)</i>			
Name of Insurance _____		Effective Date: _____	
Policy Holder of Insurance: _____	Relation: _____	Ins ID#: _____	
Holder's Date of Birth: _____	Holder's Social Security Number: _____		
Employer: _____	Phone _____		
Required to file claim			
Emp Address: _____			
(Street)	(City)	(State)	(Zip)
Secondary Insurance			
Name of Insurance _____		Effective Date: _____	
Policy Holder of Insurance: _____	Relation: _____		
Holder's Date of Birth: _____	Holder's Social Security Number: _____		
Emergency Contact			
Nearest Relative: _____		Relation to patient: _____	
Address: _____			Phone: _____
(Street)	(City)	(State)	(Zip)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Noel R. Williams, M.D. to furnish any and all information with respect to any illness or injury, and copies of all hospital or medical records to any individual, review agency or corporation in any way responsible for the payment of charges incurred and, in the event of a transfer, to any subsequent health care provider.

THIS INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFIECIENCY SYNDROME (AIDS). INTIAL HERE THAT YOU UNDERSTAND THESE TERMS: _____

ASSIGNMENT OF BENEFITS: I hereby authorize direct to the above physician and/or hospital, of the benefits otherwise payable to me, but not to exceed the physician's and/or hospital's regular charges. I understand I am financially responsible for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

Date: _____ Patient Signature: _____